California Network of Mental Health Clients

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Proposed Principles and Implementation Recommendations For the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Component

Overall Client/Survivor Representation and Involvement

Proposed Principle	Implementation Recommendations
1. Clients, survivors and ex-patients (c/s/x) must be well represented and meaningfully involved in every aspect of PEI implementation, including planning, delivery of services, oversight and evaluation.	❖ Client/survivor membership levels in county and statewide PEI stakeholder groups should be raised to a simple majority. ❖ Strategies for meaningful client involvement in PEI services should be written into every work plan and job description. ❖ This participation and involvement can be achieved though the following strategies: ➢ Contracting (directly and indirectly) with the CNMHC; ➢ Consumer staffing of the State Dept. of Mental Health (DMH), Planning Council, and Oversight and Accountability Commission (OAC), both in-house and out-sourced;[1] ➢ Volunteer client involvement in State and local PEI planning, oversight, and evaluation bodies, with a minimum participation level of fifty (50) percent plus one (1). ❖ Every approved PEI contract with a service provider organization should require that organization's board of directors to include at least one (1) client/survivor member in the contract's first fiscal year, at least two (2) c/s/x by the contract's second year, and at least three (3) or fifty (50) percent (whichever is fewer) c/s/x by the third year. ❖ State-level PEI planning and implementation meetings should always be accessible to clients/survivors from other parts of the State. The DMH should offer travel reimbursements to c/s/x who need assistance with travel, lodging and food costs. ❖ A performance measure should be developed to periodically evaluate to what extent the State DMH has prioritized and improved inclusion of clients/survivors of all ages, genders, cultures and ethnicities in PEI planning and implementation. ❖ The DMH should be required to periodically report to stakeholders on their progress in building c/s/x involvement and inclusivity in state level PEI planning, review and implementation, and in encouraging it at the county level; in particular, the DMH should provide evidence of the extent to which they are including unserved and underserved communities in the State-level stakeholder process, and document how underrepresented people are becoming meaningfully involved.[2]

[1] State agencies can eliminate a significant barrier to client/survivor employment in their agencies by offering c/s/x applicants waivers of civil service examination requirements.

[2] The term *unserved and underserved communities* must include transition age youth, older adults, communities of color, immigrant and Native American communities, persons who are dually and multiply diagnosed, people with physical, cognitive, developmental and sensory disabilities, lesbian, gay, bisexual, transgender and queer people, people with experience in the foster care, juvenile and criminal justice systems, and people who are homeless or at risk of becoming homeless.

Outreach and Engagement

Proposed Principle	Implementation Recommendations
2. PEI outreach efforts should first and foremost reach persons with mental health disabilities and persons with lived experience in the mental health system, and must prioritize peer outreach to unserved and underserved communities.	❖ Primary attention should be given to using PEI funding to hire and train client/survivor peer outreach workers and MHSA education specialists at the local level, with priority placed on hiring clients/survivors representing unserved and underserved ethnic, cultural, age and disability groups that have been underrepresented at stakeholder meetings.[3] ❖ Peer outreach work should involve brief one-on-one contact with clients/survivors from each unserved/underserved community in culturally specific settings, as outlined in the State DMH's *Community Services and Supports Three-Year Program and Expenditure Plan Requirements* for county mental health departments under Outreach and Engagement Funding. [4] [5] [6] ➢ Outreach workers must go into their respective communities on an ongoing basis and talk to other persons who are seeking, receiving, have tried to access or have received mental health services, persons who have been coercively or forcibly treated as outpatients or in hospital settings, and those who have recently exited foster homes, juvenile and criminal justice systems, hospitals or other institutions and who may be homeless. ➢ Once initial contacts are made and dialogue is established, it is critical that the term *engagement* be used in the sense of encouraging people to engage in the planning and implementation process, rather than waiting for community services and supports plans to be approved and then simply connecting people with services. ❖ Rather than reinforce negative stereotypes about clients by teaching people to "to recognize the early signs of potentially severe and disabling mental illnesses", PEI outreach strategies should use a strength-based approach, emphasizing the positive aspects of mental illness/madness, such as imagination, creativity, intuition, and emotional depth. ❖ In order to effectively combat discrimination and stigma, peer outreach efforts should focus on recruiting clients/survivors as MHSA stakeholders, expert consultants, plan reviewers, anti-discrimination trainers and evaluators. ❖ PEI client/survivor engagement strategies should include c/s/x-led client culture train-the-trainer programs, focusing on unserved and underserved populations. This training would help clients to unlearn fear and develop new skills and confidence as trainers; clients who graduate from this training could then train providers and others on client culture, as well as become peer outreach workers and MHSA education specialists. ❖ Outreach to youth, adult and older adult clients/survivors should include educational training and assistance for those who wish to go back to school. PEI educational assistance should include: ➢ Financial assistance, including but not limited to fee waivers, assistance with student loan applications, and full or partial forgiveness of student loan debts; ➢ Outreach to educators and employers, including but not limited to job fairs and client culture trainings.

[5] San Francisco's Institute for Community Health Outreach at http://www.altrue.net/site/ichoca/ trains community health outreach workers throughout the state; their training manuals, outreach logs and needs assessment surveys should be used as references to develop outreach and engagement programs.

[6] *Culturally specific settings* may include (but are not limited to) Native American reservations, rancherias and urban community centers, churches and other religious and cultural centers in African American, Latino and Asian American communities, recreation centers and after-school programs for youth, homeless people on city streets, homeless shelters and transitional housing programs for young people, single adults and families, single-room-occupancy (SRO) hotels, residential psychiatric or drug/alcohol treatment programs, board-and-care facilities, hospitals, jails and nursing homes.

[6] State and county agencies should make an effort in PEI planning or implementation to avoid lumping clients and family together as if they were one group. Outreach and trainings by clients/survivors and trainings by families should be planned and implemented separately.

Strategies to Reduce Discrimination and Stigma

Proposed Principle	Implementation Recommendations
3. State agencies that develop PEI guidelines, approve, evaluate and oversee PEI programs should create specific guidelines for strategies to reduce discrimination and stigma.	❖ The DMH should draft PEI plan requirements whereby each county must report what specific strategy it will use to actively combat discrimination and stigma. ➢ The focus should be shifted from reducing *stigma* to ending *discrimination.* Discrimination can be readily identified, and concrete steps can be taken to combat it, whereas stigma is more conceptual and ambiguous.[7] ➢ Examples of suggested strategies throughout the PEI plan requirements should be developed in consultation with mental health clients, survivors, other stakeholders, statewide mental health advocacy groups including groups representing unserved and underserved communities in mental health policy, and the OAC. ❖ The OAC should develop a strategic plan on how discrimination and stigma will be addressed. ➢ This strategic plan should be developed in consultation with clients, survivors, other stakeholders, statewide mental health advocacy groups including groups representing unserved and underserved communities, and the DMH.
4. Programs to reduce discrimination and stigma in all four age groups should be prioritized in PEI funding allocations.	❖ The OAC should allocate at least fifty (50) percent of funds from PEI program revenue for campaigns to reduce discrimination and stigma, evenly distributed across all four age groups. ➢ This allocation should include funding for anti-discrimination advocacy services and *pro bono* legal counsel for clients, survivors, current and ex-patients who report discrimination based on their perceived mental disability. ❖ The OAC should make available to local mental health programs and interested stakeholders current information and research on effective strategies for combating discrimination and stigma.

[7] The term *stigma* has been increasingly misconstrued within the mental health system to mean simply a barrier to seeking treatment. However, a majority of c/s/x focus group responses defined stigma as a pervasive form of prejudice or oppression leading to a wide array of discrimination against people labeled "mentally ill".

Strategies to Reduce Discrimination and Stigma (Continued)

Proposed Principle	Implementation Recommendations
5. Clients/survivors should always have leadership positions, full representation and meaningful participation in campaigns to reduce discrimination and stigma.	❖ When the State DMH and OAC present their draft PEI plan requirements and guidelines to stakeholders, each agency should give a detailed report on when and how it consulted with clients/survivors for input on suggested PEI strategies. ❖ The OAC, in developing the strategic plan to reduce discrimination and stigma, should consult with the CNMHC to incorporate the current state of the art knowledge on the most effective strategies, including but not limited to: ➢ Client/survivor-led trainings for mental health professionals and service providers. ➢ Client/survivor-led anti-discrimination speaking events in schools and community settings. ▪ Trainings for community groups should be conducted as community partnerships. In each different community, trainings should include one or more members of that community. For example, when working with a church, include a parishioner from that church. ➢ Client/survivor-led crisis intervention/de-escalation trainings for law enforcement and other first responders. ➢ Client/survivor-led trainings for mental health clients/survivors on personal and community advocacy strategies for combating discrimination and overcoming internalized stigma. ❖ A concerted effort must be made to include clients/survivors at every level of the planning and implementation process involving strategies to reduce discrimination and stigma, including hiring c/s/x as salaried staff, trainers and consultants. ❖ The OAC should contract with the CNMHC to assist in carrying out its duties to address discrimination and stigma.
6. Funding should be prioritized for promising, innovative client/survivor-run educational programs to reduce discrimination and stigma, as well as mutual support services and address the harm discrimination and stigma inflict on individuals and communities.	❖ A portion of discrimination and stigma reduction revenues should be used to fund local and regional c/s/x-run self-help projects to provide education for service providers, community members and others to reduce discrimination and stigma. ❖ A portion of discrimination and stigma reduction revenues should be used to fund the CNMHC to further develop, promote, and disseminate client culture training as a tool of discrimination and stigma reduction and prevention, ❖ A portion of discrimination and stigma reduction revenues should be used to fund a statewide client/survivor-run and staffed website on strategies to reduce discrimination and stigma. ❖ A portion of discrimination and stigma reduction revenues should be used to fund innovative services within c/s/x-run mutual support centers, including traditional, culturally specific, peer-run programs such as the Native American Talking Circle, that offer an effective alternative treatment of trauma, allowing people to heal from the detrimental effects of discrimination and stigma. ❖ A portion of discrimination and stigma reduction revenues should be used to fund innovative, peer-run leadership development trainings such as CNMHC's Client Leadership Training and Contra Costa County Office for Consumer Empowerment's SPIRIT Training, which inform, encourage build skills and raise confidence among emerging consumer/survivor leaders, helping to empower them to combat discrimination and stigma in their communities. ❖ A portion of discrimination and stigma reduction revenues should be used to fund further and more in-depth research by client/survivor organizations into the nature, history and social dynamics of discrimination and stigma from the perspective of people who have experienced it first-hand, focus groups, different types of studies are needed, such as surveys, oral histories and audio and video documentaries.

Addressing Discrimination, Abuse and Trauma as Primary Causal Factors

Proposed Principle	Implementation Recommendations
7. Discrimination, abuse, and the resulting emotional trauma and depression are often primary causal factors in many preventable negative outcomes that are all too often attributed to mental illness alone.	❖ All PEI programs should be wellness/recovery-based, trauma-informed, culturally and linguistically competent, adhere to recognized standards of self-directed care, and avoid the "behavior management" approach. ❖ Each county or region should offer an array of trauma-informed services to meet a wide range of needs for people of all ages, genders, cultures and ethnicities.
8. Access to voluntary, self-directed, trauma-informed PEI services, including c/s/x-run programs, is crucial both to improve short- and long-term outcomes for clients and to reduce the use of involuntary treatment and prevent hospitalization.	❖ Anyone seeking or receiving PEI services, regardless of age group, who discloses having experienced discrimination, abuse, or other traumatic events, should have access to a full array of recovery-based, trauma-informed services. ❖ PEI services should utilize a "no wrong door" approach, allowing access through drug and alcohol treatment centers, crisis residential facilities, and peer-run drop-in centers. ❖ PEI funding should be evenly distributed to all four age groups. PEI resources should be made available to adults and older adults on an equal basis with children and adolescents. ❖ Client/survivor-staffed programs, peer advocacy and support should always be considered "medically necessary care". ❖ A portion of PEI funding should be used to fund a program or programs that provide knowledge and linkage to community services and connect people who are seeking services with the type of support and information they are seeking, before they find themselves stuck in the mental health system. ➢ Peer outreach (as described on page 2 of this document) should be made available to unserved and underserved communities to connect people with culturally and linguistically competent support and information. ❖ Involuntary treatment and hospitalization are *not* outcomes of "untreated mental illness"; rather, they are the "treatment" the system reserves for the point at which people lose all hope of accessing voluntary, recovery-based supports. PEI programs that prevent hospitalization should *always* be truly voluntary and self-directed, never coercive or forced. ➢ One example of a coercive strategy that should not be recommended or funded with MHSA revenues is outreach teams or mobile outreach/treatment teams that include law enforcement officers; ➢ One example of a forced intervention that cannot be funded with MHSA revenues is short-term acute inpatient "care" (hospitalization) for individuals in Full Service Partnerships who are uninsured for acute inpatient care;[8] ➢ Another example of a forced intervention that cannot be funded with MHSA revenues is involuntary outpatient commitment, such as that provided under AB 1421 (Laura's Law).

[8] Despite the CNMHC's position paper in opposition, the State Dept. of Mental Health has proposed new language that would permit counties to use MHSA funding for short-term involuntary hospitalization for adults in Full-Service Partnerships whose insurance does not cover short-term acute hospitalization. The CNMHC strongly opposes this language.

Addressing Discrimination, Abuse and Trauma as Primary Causal Factors (Continued)

Proposed Principle	Implementation Recommendations
9. Discrimination, abuse, trauma and depression are often primary causal factors in suicide.	❖ PEI strategies to prevent suicide should include client/survivor-run warm lines (preventive talk lines) in each region or county. ❖ Suicide prevention strategies should also include client/survivor-run educational programs for community and family members to reduce discrimination and increase community and family support for people experiencing emotional distress. ➢ Such programs may involve an entertainment component, such as live music or theatre (ideally performed by clients/survivors), to entice community and family members to attend and persuade them to stay and listen.
10. Discrimination, abuse, trauma and depression are often primary causal factors in incarceration.	❖ PEI strategies to prevent both discrimination and incarceration should include a program that hires client/survivor outreach workers and researchers to conduct a series of studies throughout the State in order to identify juvenile and adult service providers, schools, police and probation departments that profile people based on perceived mental heath disability, race and homeless status. ➢ The program should then require agencies identified as having used discriminatory profiling methods to be re-trained, and hire a team of clients/survivors and legal advocates to train the staff of those agencies in client culture and anti-discrimination law, including all levels of management. ➢ Agencies that have received more than three (3) separate complaints of discriminatory practices should be required to pay fines based on their revenue; these fines should be fund the re-training portion of this program. ❖ PEI programs that prevent incarceration should *always* be truly voluntary and self-directed, never coercive or forced. ➢ Examples of coercive programs that should not be recommended or funded include mental health courts and coercive jail diversion programs for youth or adults.
11. Discrimination, abuse, trauma and depression are often primary causal factors in school failure and drop-out.	❖ PEI strategies to prevent drop-out and school failure should include client/survivor-led mutual support programs on college and university campuses, as well as high schools and vocational education centers. ➢ Such programs should include student client/survivor-run train-the-trainers and educational improvement training components by which students may educate the educators on discrimination and cultural competency, including client culture. ➢ Disabled students programs should be trained and staffed with consumers and survivors to provide support for students labeled with "mental illness" or experiencing emotional distress who are at risk for dropping out. ➢ The "contact" model should be used to address discrimination and stigma on campuses, allowing students, faculty and staff to meet a panel of clients and survivors, who may share their personal experiences and/or opinions and answer questions.

Addressing Discrimination, Abuse and Trauma as Primary Causal Factors (Continued)

Proposed Principle	Implementation Recommendations
12. Discrimination, abuse, trauma and depression are often primary causal factors in unemployment.	❖ Employers should be mandated to participate in education on discrimination and stigma; counties should require employers of a certain size to hire consumer/survivors to train their staff. Hiring and workplace discrimination must be taken seriously before it can be stopped.
13. Discrimination, abuse, trauma and depression are often primary causal factors in homelessness.	❖ PEI programs to prevent homelessness should focus on preventing the factors that lead to homelessness: ➢ Discrimination by landlords (including board-and-care operators, master tenants and non-profit "supportive housing" management); ➢ Domestic violence (including violence in LGBTQ relationships); ➢ Family abuse against teenagers (including foster families and group homes) and adults (including shut-ins); ➢ Discrimination in emergency shelters and transitional housing programs (including domestic violence shelters and "safe houses" for runaway youth); ➢ Lack of proper discharge planning upon release from hospitals and jails.
14. Discrimination, abuse, trauma and depression are often primary causal factors in mental health problems in children and/or their parents, which in turn can result in removal of children from their homes.	❖ PEI strategies to prevent removal of children from their homes should include programs that help parents be there for their children when the children are experiencing emotional distress, to listen to what their children have to say and offer support, rather than "behavior management". ❖ PEI strategies to prevent removal of children from their homes should include harm-reduction-based programs that help homeless parents get their housing and their children back. ❖ PEI strategies to prevent removal of children from their homes should recognize that racism and cultural bias are often factors in decisions to remove children from their homes in communities of color. The California Association of Social Rehabilitation Agencies (CASRA) has promoted a strategy to bring culture back to people, for instance, to allow Native Americans to practice their traditional culture. ❖ PEI strategies should be developed that offer voluntary, proactive, culturally and linguistically competent, peer-run, community-based alternatives to Child Protective Services (CPS) and mandatory parenting classes, which are punitive and crisis-based. Alternatives are needed that will prevent children from being removed from the homes of consumer/survivor parents. A wide array of comprehensive services should be developed to educate parents of all ages, including teens, on how to be parents. The bottom line is that these services must be voluntary and accessible, and made available instead of simply taking kids away.
15. Discrimination by mental health service providers based on whether a person's diagnosis fits into a "target population" is often a primary factor in prolonged suffering, hospitalization, and encounters with law enforcement.	❖ New, voluntary, c/s/x-run PEI services are needed as a viable alternative to this dysfunctional, crisis-based model. ➢ Access to PEI services should always be based on the self-assessed need of the person seeking those services, rather than with which diagnostic category that person has been labeled. ➢ Under the outdated crisis-based model, people who ask for help are often denied services because their diagnosis doesn't fit into the public mental health system's predetermined "target population." So they're unable to access any services until they're in a crisis, at which point they become a target for abuse by police and the mental health system. They're forced into treatment, hospital and/or jail, when all they are asking for is voluntary services.

Addressing Discrimination, Abuse and Trauma as Primary Causal Factors (Continued)

Proposed Principle	Implementation Recommendations
16. People labeled "mentally ill" suffer from internalized stigma resulting from a discriminatory social environment.	❖ Language in the MHSA about prolonged suffering should be interpreted in the broadest sense to reflect the reported experiences of clients/survivors of all ages, rather than the purported symptoms ascribed to them by professionals. [9] ❖ Reports by c/s/x of discrimination from within the mental health profession should be taken very seriously and studied categorically; transformative remedies should be developed for this systemic problem. ➢ PEI strategies to prevent prolonged suffering should include programs that would prevent the suffering that results from the trauma of discrimination and abuse so often experienced in the foster care, juvenile and criminal justice systems and in forced psychiatric interventions. Examples of these types of prevention programs can be found throughout this document.
17. Hospitalization, eviction, out-of-home placement of children and youth, unemployment, and loss of one's belongings are often a direct result of discrimination, and can often be prevented by taking proactive steps to reduce discrimination.	❖ **Measures should be taken to ensure that if a client/survivor is hospitalized, that person does not lose his or her home, children, employment or belongings.** ➢ PEI strategies to prevent homelessness should include peer support and legal advocacy to minimize the length of time people are held in the hospital if they are involuntarily committed, and financial support and legal advocacy to prevent landlords from evicting tenants whose hospitalization delayed their ability to pay rent on time. ➢ PEI strategies to prevent removal of children from their homes should include the above components, plus free childcare by a trusted babysitter or licensed childcare worker approved by the person who is hospitalized, for the duration of the hospitalization, to prevent out of-home placement. ➢ PEI strategies to prevent unemployment should include the above measures, plus legal advocacy if the employer learns of the c/s/x employee's hospitalization and pursues a discriminatory course of action. ➢ Homeless people should be informed of their right to keep their belongings if they are 5150ed or hospitalized. A Possessions Advanced Directive (PAD) can be used to prevent hospital staff from throwing away homeless people's belongings if they are committed.

[9] When non-labeled people say that we "suffer from untreated mental illness", such statements are offensive, inaccurate and defamatory. Policies written from this framework invite pity and paternalism at best, and more often fuel discrimination and abuse. C/s/x participants in ten of the twelve focus groups in the CNMHC's discrimination study reported a significant amount of discrimination by mental health professionals or the mental health system as a whole, and five groups reported more incidents of discrimination within the mental health system than in any other category. The study revealed that the mental health system was the leading source of discrimination, reported in 21% of the total responses.

Community-Oriented, Client/Survivor-Run Approaches

Proposed Principle	Implementation Recommendations
18. Community-oriented alternative approaches should replace the outdated, ineffective maintenance/stabilization model.	❖ Recommended PEI strategies should include a client/survivor-staffed Soteria-style project, a voluntary residential program for people labeled with schizophrenia or other Axis I disorders, that employs wellness/recovery modalities and trauma-informed peer support, rather than medication maintenance/compliance, which is not prevention-based, and which can prolong and perpetuate illness, as well as reinforce discrimination and stigma.[10] ❖ Recommended PEI strategies should include new alternative, holistic services, as well as social networks for personal support. ➢ Personal support networks can include spiritual resources, like attending a church or participating in a faith community where one feels supported.
19. To prevent school drop-out and other negative outcomes, schools should facilitate mutual support and empowerment among students with lived experience in the mental health system, and move beyond the limitations of traditional "supported education".	❖ PEI drop-out prevention strategies should include a program modeled after the innovative, student client/survivor-run Beauty Path Office proposed at San Jose City College, which would facilitate mutual support and education-based recovery. This proposed program offers hope as a model for empowering students with lived experience in *all* levels of education. ❖ Strategies must be developed to end the segregation of clients/survivors and other young people with disabilities in schools and at work, which prevents them from accessing or asking for assistance before things get out-of-hand. ➢ The traditional model of "supported education" often involves segregation of students with disabilities, condescending attitudes, and a "one-size-fits-all" approach. ➢ Components of PEI drop-out prevention programs should be dedicated to improving c/s/x student access to the full array of educational opportunities, using a combination of "contact" events and client culture trainings to encourage acceptance among both students and educators.
20. Well-funded, serious programs directed towards meaningful employment for consumers/survivors are needed to end the prolonged suffering related to unemployment.	❖ Strategies should be developed for client/survivor-run programs that train and support clients and survivors to find productive, meaningful activities or jobs, even when they aren't feeling well at that time. ➢ Long-term unemployment reinforces depression, and often leads to other, prolonged negative outcomes. Currently, more than eighty (80) percent of adult clients/survivors are unemployed. ❖ Strategies should be developed for programs that train and encourage clients/survivors on Supplemental Security Income (SSI) and other disability benefits to find meaningful work and apply themselves, rather than continue to allow the earned income restrictions for those programs to discourage people from seeking employment.

[10] SAMHSA's *National Consensus Statement on Mental Health Recovery* offers an excellent primer on recovery principles; copies can be ordered or downloaded at http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/.

Community-Oriented, Client/Survivor-Run Approaches (Continued)

Proposed Principle	Implementation Recommendations
21. Client/survivor-driven community advocacy is needed for clients who have been, or are at risk of being, hurt or killed by law enforcement in intervention situations.	❖ PEI strategies to prevent discrimination and incarceration should include client/survivor-run peer advocacy groups to support c/s/x survivors of police abuse and those who are at risk.[11] ➢ A c/s/x-driven, anti-oppression model should always be used that is *truly* voluntary, free from coercion or force; clients must always have the option of refusing any and all treatment offered without facing jail or hospitalization. ➢ A c/s/x-run training program should be developed for c/s/x to provide this type of support and prevent crises. ❖ Clients/survivors can often de-escalate potential crisis situations, such as disputes with family members or partners, much more effectively than police. PEI strategies to prevent discrimination and incarceration should include a c/s/x-run pilot program allowing a county to dispatch a mini-support team of clients/survivors to the scene instead of police, so the problem does not escalate any further. We can often prevent problems from getting worse without involving the police. ❖ PEI strategies to prevent discrimination and incarceration should also include a c/s/x-driven public education campaign on how to respond to people in emotional distress in other ways besides calling 911, because this all too often results in clients/survivors being unnecessarily killed, or arrested and either taken to jail or hospitalized. The public needs to know that *peer support* can be more effective than calling 911. ❖ PEI strategies should also include a crisis-prevention warm-line, so clients can reach peers easier in situations like these. This would give clients a way to approach others like them, who can listen and help them calm down.

[11] As we stated earlier in this document, PEI programs that prevent incarceration should *always* be truly voluntary and self-directed, never coercive or forced. Examples of coercive programs that should not be recommended or funded include mental health courts and coercive jail diversion programs for youth or adults.